

THE MEDICAL AND SURGICAL REPORTER.

No. 497.]

PHILADELPHIA, SEPTEMBER 8, 1866. [Vol. XV.—No. 10.]

ORIGINAL DEPARTMENT.

Communications.

AMBYOPIA, AMAUROSIS, AND THE EXTRACTION OF CATARACT.*

By LAURENCE TURNBULL, M. D.,
Of Philadelphia.

This translation was made during the past winter, for the *Boston Medical and Surgical Journal*, and is now collected from its pages. Its publication is stated by the translator for the two-fold object of introducing ALBRECHT VON GRAEFE to the American medical public as a clinical teacher, and of exhibiting the progress which has been made in the exploration of one of the most obscure departments of ophthalmic science.

These lectures were compiled and reported by Dr. ENGELHARDT, and were translated from the *Klinische Monatsblätter für Augenheilkunde* for 1863 and '65. From our earliest attempts to master the subject of ophthalmology, these terms amblyopia and amaurosis have constantly stood in our way, as being arbitrary and used by all writers on diseases of the eye to express loss or defects of vision, and when the ophthalmoscope was brought into practical application, we trusted with others, that these indefinite terms would pass away, and give place to terms of a more positive nature. But alas, the day has not yet come, for the recognized head of this department, as late as 1865, employs the same vague and uncertain terms, and thus writes and lectures upon them to students from every part of the world.

"In cases of amblyopia,† (from this class we, of course, exclude all those affections which proceed from visible changes in the *refractive media*, or in the *internal structure* of the eye, as also cases of *neuroretinitis* and *embolia*) three things

aid us in general in arriving at our conclusions. First, the *functional state* of the eye carefully considered; second, the *appearance of the papilla*; third, the *manner in which the affection has become developed*. Ordinary daylight is insufficient to detect slight defects in making a general examination of the periphery of the field of vision. This is to be conducted in a darkened room where the light proceeds from a graduated lamp, and a diaphragm being set at 100, and a black paper, without gloss, being held before the patient, (of course, at a fixed distance,) the limits of the field of vision are ascertained by means of white balls set on a black rod, and gradually removed from the point of fixation."

According to our author, the ophthalmoscope has determined that there are defined bounds to the class of amblyopic affections, by the exclusion of other intra-ocular diseases, and that there are four characteristic diagnostic points obtained by its use: *a*, alteration in color (of the optic nerve); *b*, opacity; *c*, excavation, and *d*, diminution of the calibre of the vessels. In the curative form, the papilla retains its delicate, semi-transparent color.

The following causes are given as producing this affection: The immoderate use of alcoholic liquors, frequent indulgence in strong cigars, pelvic obstructions, catamenial derangements, cold extremities, suppression of habitual hæmorrhagic discharges, or of pathological or physiological secretions, venereal excesses, irregular sleep, and immoderate use of the eyes, sometimes exert a separate, sometimes a combined effect, and it is then difficult to assign each their part.

His treatment of a case of congestive amblyopia, with normal field of vision, is as follows: The use of alcoholic beverages must be given up, that of tobacco reduced to a minimum, regularity in diet and sleep. Local depletion, a rapid evacuation of blood by the leech of HEURTETOUR, or by cupping in the neck. In hæmorrhoidal affections leeches to the anus, and in disorders of menstruation, cupping on the inside of the thighs. His diaphoretic treatment is principally (in imitation of many older practitioners) carried out by means of the decoction of ZITTMANN and the Roman or Turkish

* Being a Review of "Clinical Lectures by Prof. A. VON GRAEFE, translated by HASKET DEBET, M. D., Surgeon to the Massachusetts Charitable Eye and Ear Infirmary, etc. etc." David Clapp & Son, Printers, 384 Washington street, Boston. 1864. Pp. 86. Letter from Berlin, Jan. 27th, Ophthalmological Department Cincinnati *Lancet and Observer*, May, 1866. Pp. 310, 320, and 321.

† Obscurity of Vision.

baths of dry heat instead of vapor. Abdominal disorders are treated by the use of the mineral springs of Marienbad, Kissingen, Homburg, and Carlsbad. Good and regular sleep must be had, and affords the most grateful refreshment to the active nerve of vision.

Having thus given what we consider the most interesting and instructive epitome of the author's views on the subject of amblyopia, we shall pass to the consideration of amaurosis. The course of the most desperate form is as follows:

"Slowly, but not regularly so, in the course of months or years, the field of vision of the first eye becomes contracted, (generally irregularly, laterally,) its acuteness of vision diminishes, atrophic degeneration of the papilla takes place, and the organ is lost, while after the first eye has begun to be affected, sometimes not till after its entire loss, the second commences to run the same course. These cases are indeed utterly hopeless; they are regarded as a *noli me tangere* by the experienced physician, who cautiously refrains from active treatment, knowing that this may easily harm, and at the best can be of little service.

A few remarks may be added, on the nature of amaurosis. Where there are no objective intra-ocular symptoms in cases of impaired vision, we are apt to speak of cerebral or spinal amaurosis. Especially interesting is the connection of progressive amaurosis with paralysis and mental alienation—the course of the degeneration is from the vertebral column toward the interior of the skull. Of all the many cases of spinal amaurosis, (forming as they do, some thirty per cent. of the graver forms of progressive amaurosis,) which has come under VON GRAEFE'S observation, he can recollect but two instances where the disease progressed in an opposite direction. It may be regarded as a fixed fact that there is no question of an inflammation of the nerve connective tissue, in the ordinary sense of the word, in amaurosis or tubes dorsalis. By the ophthalmoscope it is found that in the optic papilla there is either simple loss of substance, (atrophic excavation,) the most perfect type of a true atrophic process; sometimes there occurs a gradual consolidation of the connective tissue, the papilla growing smooth, white, and opaque, while the lamina cribrosa becomes hidden.

Having given his treatment of a case of congestive amblyopia, we shall now give an abstract of his treatment of a case of progressive amaurosis, depending on atrophy of the optic nerve.

It is simply necessary to state that all powerful derivative agents, cathartics, searons, mercur-

rials, diaphoretics, and depletives, beneficial as they may be in cases of congestive amblyopia, (Case 1,) are here decidedly injurious. In the average of cases of progressive atrophy, the best means of retarding its progress consists in a mild tonic course—small doses of an iron salt, and tonic baths, milk and whey diet; in other words, a nutritious, but not stimulating diet, good air, a moderate course of cold bathing, and carefully regulated amount of light. Cases 3 to 8 are interesting and also instructive, and are well worthy of perusal, but our want of space prevents us from entering even upon an abstract.

In concluding this part of our subject, we may state that the terms amaurosis and amblyopia are merely symptoms of diseased eyes. The true typical symptoms are a diminution in the acuity of vision, (*s*) and should be carefully investigated by test types, optometer, by concave and convex glasses, and the ophthalmoscope.

The "Clinical Remarks on a Case of Extraction of Cataract" occupy twenty-four pages. A few practical points we here marked, and first, as to simple cataract, if there is such a thing, "are those cases where we are unable to discover any affection of the deeper structures of the eye, and no break exists in the nervous apparatus. Only one eye should be operated upon at a time." The translator corroborates this from WECHE, who states that the elementary principles of prudence indicate sufficiently the impropriety of performing the operation of cataract on more than one eye at a time.

The opinion of some of VON GRAEFE'S colleagues, that extreme age does not exert a particularly unfavorable influence on extraction, is most emphatically contradicted by his tables, which show, after the 65th, and particularly after the 70th year, a considerable falling off in the percentage of recoveries.

A sunken position of the balls has been particularly dwelt upon as an unfavorable circumstance, in so far as it interferes with the mechanical execution of the operation. This is only so when it depends on general marasmus and coupled with senile diminution in the diameter of the cornea. The tendency of iritis is decidedly greater in marasmic eyes, (increasing, as it does, in proportion to the age.)

Taking all the circumstances into account, the general prognosis of flap extraction must be here essentially modified. According to his reckoning of 100 cases of flap extraction, 65 result favorably, by which he means the gaining an acuteness of vision of at least $\frac{1}{4}$; if more than 75 years of age, of at least $\frac{1}{2}$. In 15 of the re-

maining 35, a favorable result is attained by a subsequent operation, consisting either in an operation for secondary cataract, or in an iridectomy with an operation for secondary cataract; of the 20 that now remain, about a third get at least vision enough to go about alone, (acuteness of vision 1-50 to 1-30,) a second third gain still less, and from 6 to 8 per cent. of all eyes operated on remain or become entirely blind."

What advantage is to be gained by combining an iridectomy with flap-extraction? Does it ward off the danger of diffuse suppuration of the cornea? Not in the least. While it appears that iridectomy offers no protection against the occurrence of diffuse and partial suppuration, on the other hand, it does insure a more favorable course of things, and to a certain extent prevents the occurrence of iritis and prolapse of the iris. All so-called *preparatory treatment* is not only superfluous, but mischievous, unless indeed, there are special circumstances in the individual case requiring attention. It is sufficient to induce a gentle evacuation, by the use of castor oil or some other mild laxative, the day before the operation.

If we have a chance of previously watching the patient, it would be well to test the effect of a dose of morphine at least two days before the operation, in order to ascertain how the individual is affected by a drug we are so likely to subsequently employ, and which acts so differently in different cases. Use the upper section, if we adopt the compressive bandage. In accordance with our usual practice, operate on the patient in bed. Special stress is laid on the proper management of the bandage after the operation. "The orbital hollow is first evenly packed with charpie, which has been picked over and put together in the form of small tufts, the whole being secured by a single turn of a snug-fitting flannel bandage passing over one eye. This is held in place by another single turn around the forehead, the first half of which comes before, the other half after the turn passing over the eye. The middle portion of the bandage passing over the eye is knit of cotton, and not of flannel. Tolerably firm pressure must be made during the first few hours, and then gradually relaxed, in order not to hinder the escape of liquid secretions."

The author gives the details of a case of a female, aged 64, which we cannot follow, but sufficient for us to give the result after the operation. The entire corneal wound becomes infiltrated with opaque yellow matter, to the extent of nearly 1", and evidently throughout its entire thickness. The whole corneal flap has a yellow-

i-h, sodden appearance. Through its upper third alone is the iris visible, and the re-establishment of the anterior chamber evident. The cut edges are not in contact. The suppuration is not from the iris, but from the cornea. What can we do that will tend to limit the suppuration? Shall ice-cold applications be made? No. Application of leeches? No. Shall venesection be performed? No. What remains to be done—the bandage changed every three hours, subsequently at longer intervals, in case the suppuration shows the desired diminution. Between the applications of the bandage, camomile fomentations, at a temperature of 95°, are to be used on the lids. The diet to be bouillon, and to drink milk. The operation was performed, we should judge, on the 4th of January. On the 9th, the warm fomentations we omitted, and atropine to be instilled.

January 20. The progress of the case has been as favorable as could possibly have been anticipated. The purulent infiltration in the vicinity of the wound has become more and more consolidated, and will leave a cicatrix about $\frac{3}{4}$ " in breadth. A tissue in process of organization may be seen to extend from the wound to the pupil, indicating the course of the previous suppuration. The effect of the atropine may be seen in an enlargement of the pupil upward—artificial pupil entirely filled and contracted favorable for a subsequent iridectomy, and this he considers due to the *constrictive bandage* kept up for five days after the date of the last record. The results would have been more favorable if the bandage had been used earlier.

In concluding our notice of Dr. DERBY's translation, we most heartily thank him for his labor of love for our benefit, for it is a most valuable addition to our knowledge of the subjects treated of, more especially that part of it on the difficulties and dangers of all the forms of extraction of cataract. The customary mode is to report only successful cases, and so to give the impression that in the great majority of instances it is a successful operation. But our experience of the last twenty years has demonstrated the falsity of many of the reports in regard to this operation, and indeed of all operations for the removal of cataract. We find that, since 1863, GRAEFE has modified his operation, and his new method of extraction he calls "the modified linear extraction." According to Dr A. D. WILLIAMS, "since June, 1865, he has practised this new operation exclusively in all cases of adults where the cataract is hard." A full translation of this method, by Dr. SANELSON, will be found in course of

publication, with illustrations, in the *London Ophthalmic Review*, which we before referred to, but we, in our short notice, prefer the letter of an American physician, who gives a more concise description of the *modus operandi* and results. The patient lies on a sofa or couch, as usual. Chloroform may be administered or not, as may be thought best by the operator or desired by the patient.

"A strong wire speculum is introduced, which holds the lids wide apart. The eye is fixed with a forceps by fastening the conjunctiva near the lower margin of the cornea, and can be turned downward, or in any desired direction. When thus depressed and held by the forceps, the eye is ready for the incision. The knife used is very small, varying from one to one and a quarter inches in length, and from one and a half to two lines in width at its widest part. The point is very fine and sharp, and passes almost without resistance through the cornea. The incision is made directly upward, the eye of course being held in proper position. The sclerotica is punctured as far back as possible, so as still to enter the anterior chamber directly in front of the outer margin of the iris. The knife is now carried forward in the direction of the centre of the dilated pupil, until it passes beyond that centre, when it is turned upward close in front of the iris, on the opposite side, where the *counter-puncture* is effected, through the sclerotica. It is now held close to the anterior surface of the iris, and by a gentle sawing motion the flap is completed. When the section of the sclerotica is accomplished, the edge of the knife is turned directly forward, so as not make too large a conjunctival flap. The length of the wound should embrace about one-third of the circumference of the eye, parallel with, but behind the margin of the cornea. The conjunctival flap is now moved out of the way by gently laying it back with a pair of forceps toward the cornea. The iris generally prolapses, and now lies perfectly naked in the wound. Simple iridectomy, in the usual, well known way, is next made, and must be large, extending from one end of the incision to the other. The large iridectomy facilitates very much the exit of the cataract, by making the opening through which it has to pass out freer. Now comes the incision of the anterior capsule, which is done in a peculiar way. For this purpose, a common hook, slightly bent so as to facilitate its introduction into the anterior chamber, is used. It is passed in front of the lens, till it comes nearly opposite the lower margin of the expanded pupil, when by rotation, the point is brought in contact with the capsule. Then by gently drawing it upward and inward, the capsule is divided entirely to the upper and inward margin of the lens, terminating at the edge of the artificial pupil. A second slit is now made, starting from the original point, and terminating at the upper and outer margin of the cataract and the corresponding edge of the new pupil. In this way the capsule is opened in the form of a V, with the base upward, so that every possible obstacle to the escape of the cataractous lens is removed. Now, how is the lens

to be extracted? He makes use of a pretty large scoop, and bent at a more accurate angle than that of DAVIEL, for convenience of manipulation. The posterior lip of the scleral wound is now pressed gently downward and inward, so as to bring it rather beneath the upper edge of the lens, and thus allow the cataract to slip out. Should this not succeed, he makes a 'sliding manœuvre' from right to left, or *vice versa*, along the posterior lip from one end to the other, pressing it inward at the same time, as much as is advisable. This simple movement frequently resulted in loosening the cataract, and causing it to escape. If this in turn, does not succeed, he lays down the scoop, and takes a small hook made expressly for the purpose, and introduces it through the capsular opening at the upper margin, passes it carefully behind the lens but within the capsule, till its point reaches near the lower edge of the same. The hook, of course, introduced with the plane of the point parallel to the capsule, is now turned with the point forward, and pressed into the hard substance of the lens. By very slight traction the cataract is drawn out. It is to be supposed that one or the other of these three manœuvres will be successful. Up to the present time I have not witnessed a single operation when they all failed. From my observations, the hook will have to be used in about half the cases. As in all other operations for extraction, these manipulations must be made with gentleness and caution, and *never* in a hurry, or with force. These delicate precautions are necessary to avoid the rupture of the hyaloid membrane and escape of vitreous humor. After the hard nucleus is removed, the remaining soft cortical substance is induced to escape by gently rubbing the lower lid over the cornea a few times, from below upward, as in ordinary flap extractions. The wound in the sclerotica is now cleared carefully of all particles of lens, or coagula of blood, so that the coaptation may be perfect. The flap of conjunctiva is now turned back into its natural position, and nicely adapted with the forceps, so as to cover the wound in the sclerotica. The eye is at last closed, the orbital cavity filled up with charpie, and over this the usual bandage, moderately tight, is applied. I should have mentioned before, that the speculum and fixation forceps are removed immediately after the exit of the nucleus or bulb of the cataract. The patient is kept quietly in bed, and free from all excitement, and not allowed to talk or chew anything hard. The diet is restricted to rather a minimum quantity of fluid articles, and the patient is not allowed to rise up, unless it is absolutely necessary to answer the calls of nature. Some six or seven hours after the operation the eye is opened, the charpie replaced by fresh, and the bandage reapplied. The following day the bandage is taken off twice, and atropia instilled into the eye, and this is repeated each day. By keeping the eye bound up several days, the possible springing of the wound is avoided, an accident by no means uncommon after flap extractions. Only one instance of this kind is reported, after the operation by GRAEFÉ's method. The operations are all made down stairs, so that the patient must rise and be led up two or three flight of stairs to their

rooms. On an average, patients are discharged, after the operation, in from ten to twelve days, and some even *inside of a week*. On the second day they are allowed to sit up if they wish. I see persons here who are operated on Friday, and on Monday are taken down to the lecture-room to be presented to the class, and again walk up the stairs to their rooms. Such a thing would hardly be allowed within ten days after an ordinary extraction. The wound in the sclerótica heals first by intention, and in a remarkably short time. The conjunctival flap unites very soon, by means of its sub-conjunctival tissue to the episclera, and thus completely closes the wound in the sclerótica. A *cystoid cicatrix*, which occurs so often after iridectomy in glaucomatous eyes, has not yet been observed after this modified form of linear extraction. By *cystoid cicatrix* is meant those instances where the cut in the sclerótica does not heal, but allows the aqueous humor to escape through it under the conjunctiva that has united over it—thus forming a bladder or little cyst—hence the name. This form of cicatrization after iridectomy for glaucoma, is not owing to the fact the *incision is made in the sclerótica*. The cause is to be sought in the nature of the disease, especially the unnatural tension of glaucomatous eyes, which predisposes to healing by such a process.

"The reaction after GRAEFÉ'S new method, is very inconsiderable indeed. The conjunctiva, it is true, reddens smartly from the incision and the irritation produced by the fixation forceps, but the cornea and sclerótica only exceptionally, take on even a slight degree of inflammation. As a rule, little or no pain follows the operation, and no constitutional disturbance. Some stress has been laid on the question as to who shall hold the forceps during the different stages of the operation. This, I think, may be left to the option and convenience of the operator. He may fix the eye himself, or entrust it to a safe and reliable assistant.

"In the brief account which I have given of the 'modified linear extraction'—a method that promises, sooner or later, to come into general use—I have confined myself to a statement of the different steps in the *normal* operation, and have avoided purely theoretical questions. GRAEFÉ, in the article above cited, gives the results of sixty-nine cases operated by his method. Of these, none were completely lost. There were sixty-two perfect, and seven imperfect results. Among the latter were six who could see comparatively well, and two at the time of his writing. (Aug. 1865), stood a fair chance to get better vision without a second operation. Four will have to be operated on for secondary cataracts, an occurrence not at all uncommon after all cataract operations. In the seventh case, the sight was very imperfect, but there was a tolerable prospect of improvement by subsequent removal of the opaque capsule."

In regard to this modification of VON GRAEFÉ'S, it must be tested by numerous operators before a true verdict can be given. Dr. WECCKER speaks in his recent work in the most favorable manner of *his method*, which is the extraction of cata-

ract, together with its capsule, without laceration, under the influence of ether, which anæsthetic he prefers to chloroform.

ON EXTRACTION OF SOFT CATARACT BY SUCTION.

By A. D. HALL, M.D.,

Surgeon to Wills (Ophthalmic) Hospital.

Philadelphia.

The remarks which I am about to offer are upon a subject of every day occurrence, and one that in some of its phenomena does not receive the attention that it deserves. An injury of the lens, as usually inflicted by the point of an umbrella, or parasol, the prong of a fork, pieces of glass, gun-caps, fragments of coal, grains of gun-powder, and the various missiles familiar to practitioners, is not confined to the lens alone, but is very often complicated with iritis, either occurring primarily from the injury received by that structure in the course of the wound; or secondarily, from the swelling up of the lens, owing to the rupture of its capsule, permitting the aqueous fluid to flow in, distending its structure, and causing it to press forward upon the iris and ciliary process, giving rise to tedious, painful inflammation, with its serious results.

Almost daily, surgeons having much to do with ophthalmic practice meet with cases of this kind, where plainly the existence of iritis is not recognized, and irritating eye washes are prescribed, at the expense of valuable time, and the possibility of an occluded pupil; and yet these are the cases that are liable to occur to any one, and the ready diagnosis of which may turn the scale, for or against the eye.

Let us take a typical case. A man receives a blow or a puncture, with a sharp instrument. There is a wound of the cornea, a few lines in length; in the course of a day or more, we see a cloudy opacity of the lens; and still further, a gaping wound of the capsule, with some portions of opaque lens-substance pushed out into the anterior chamber, which we also see is diminished in size; there is intense ciliary congestion, the cornea looks cloudy and roughened, the iris has lost its natural hue and shape; and even more than the loss of sight, the man complains of intense pain; pain in his temple, and back of his head, depriving him of sleep and comfort. His sufferings are so great, that he tells you he must have ease. Now what will relieve him? will leeching? will opium, will atropia instillation relieve him? Not always. What will do so? When the indications are present, make a linear opening in the cornea, introduce a curette, and allow the fluid

lens tissue to run out. The man is relieved, and blesses the hand that saves him pain. This injunction, however, requires some qualification; in the cases of children, for example, for in them there is less danger of troublesome symptoms following these injuries; and we can afford to wait longer than we can in the cases of adults, or old people, in whom very little swelling of the lens will excite the most dangerous symptoms.

Cases of soft cataract are, as a general rule, readily curable by a needle operation. In those cases in which the lens assumes a semi-fluid form, the extravasation of its contents, which appear to possess some irritating properties, not unfrequently gives rise to serious inflammation, and this untoward event is prevented by the operation of suction, by which the lenticular matter is immediately removed from the eye. Although in the following case the operation proved highly successful, I would not recommend its indiscriminate employment.

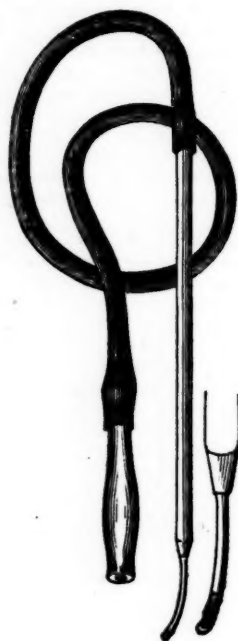
The needle operation has the advantage of doing all that can be done by suction, without its dangers. And that the wound of the cornea, and interference with the eye in suction, may lead to inflammatory trouble in certain cases, any one familiar with eye surgery must feel instinctively. It adds, however, one more resource to the armamentarium of the surgeon, and may be used in cases where rapidity of cure—regardless of possible risk—is a matter of some consideration. In performing this operation, Mr. TEALE recommends that the capsule be lacerated by two needles, introduced from opposite sides of the cornea. The capsule then to be freely torn open, and allowed to retract behind the iris. This is not necessary, and it would be a dangerous operation for every one to undertake. The force of this remark will be appreciated by any one who uses two needles for the first time.

Practically, it is much simpler to combine TEALE'S two steps in one. That is to say, open the cornea, and lacerate the capsule with one and the same instrument. This will appear shortly. The instruments required are the ordinary broad-cutting needle, (such as is usually supplied in cases of eye instruments,) and the suction apparatus. The cutting needle should make a wound large enough to admit the curette; nothing is gained by a larger opening.

The suction instrument is well portrayed in the wood cut; it is simply a light glass tube, with the tubular curette fixed at one end, and the flexible tube with a mouth-piece at the other.

The curette "is the size of the ordinary curette, but differs from it in being roofed in, to within a

line of its extremity, thus forming a tube, flattened on its upper surface, and terminating, as it were, in a small cup."



The Operation.

The pupil having been fully dilated by atropia, the surgeon introduces the cutting needle at a point of the cornea opposite the dilated pupillary margin, passing on his instrument he ruptures the capsule of the lens, and if required, by a little lateral movement, increases the size of his incision.

Withdrawing the needle, the curette is introduced, and passed gently into the lens; taking care not to sink it too deeply into its substance, lest when suction is applied, the posterior capsule should be drawn in too forcibly, be ruptured, and produce prolapse of the vitreous, thus complicating, at least unnecessarily, the progress of the case.

The curette then being in position in the lens, suction is to be made gently and steadily; if made quickly, or by fits and starts, you withdraw too rapidly, or draw in tissues not desired.

By this method you will clear the pupil in a moment, and will have the cataract "bottled up" in the glass tube of your instrument.

In the following case, the eye had done so well by the third day after the operation, that with a two and a half inch convex glass the patient could read No. 4½ of SNELLEN'S type.

For the report of the case I am indebted to Dr. WM. W. McCURE, the excellent House-Surgeon of the Wills Hospital.

Mary F—, aged 45; single; of good general health, received a blow on the right eye, five weeks ago, resulting in traumatic cataract. In the right, or cataractous eye, she had mere quantitative perception of light. The lens was quite opaque, and of a milky color. The pupil was active, and free from adhesions.

Aug. 9th, 1866. The operation was performed, as described above, without any difficulty, or drawback, and cleared the pupil completely. The patient at once could count fingers, and see the faces of persons surrounding her.

Aug. 10th. Free from pain. The dressings, with the exception of the adhesive strips, were removed; the eye and adjacent parts were bathed with a solution of atropia; a little being allowed to find its way in between the lids, without disturbing them.

Aug. 12th. (Four days after the operation.) The dressings were now thrown aside, vision having been completely restored, the eye in good condition, and the wound in the cornea healed.

Aug. 24th. Fifteen days after the operation, an examination at the patient's home gave the following results. With 2½ convex glass can read No. 2 of SNELLEN readily, and with a little effort can see No. 1½, and no doubt in the course of another fortnight she will read the last with ease.

It is a little singular that Mr. DIXON, in the last edition of his work, when briefly treating of the operation by suction, supposed to have been originally employed by the ancient Persians, while referring particularly to MM. LAUGIER and BLANCHET, should make no mention of Mr. TEALE, to whom we are indebted for a very ingenious mode of practical application.

Bibliography.

For those who may wish to follow up the literary history of the operation, I have appended a few references to authorities on the subject. I am indebted to Mr. TEALE for many of them; others I have added myself. That I have not been able to consult WECHE's great work, the latest and most exhaustive on the whole subject of ophthalmology, is a matter of sincere regret.

Arlt, Krankheiten des Auges. Band II. 352.

Desmavies, Maladie des Yeux, tome III. 325.

Dublin Quarterly Journal, May, 1848.

Annals d'Oculistique, vol. xvij., p. 29.

Ophthalmic Hospital Reports, vol. II., part II., p. 141.

British Medical Journal, July 9th, and Sept. 3d, 1864.

The Lancet, Sept. 24, 1864, p. 348, and Ophthalmic Hospital Reports, vol. IV., p. 149.

Dixon, Practical Guide, etc., Amer. edition. 1866. P. 353.

Laurence and Moon, Ophthalmic Surgery. London. 1866. P. 91.

Spruce st., Sept. 1866.

BIOGRAPHICAL SKETCHES OF Distinguished Living New York Physicians.

By SAMUEL W. FRANCIS, A. M., M. D.,

(Fellow of the New York Academy of Medicine.)

VI.

James Anderson, M. D.,

(President of the New York Academy of Medicine.)

"An honest man, close-buttoned to the chin, Broadcloth without, and a warm heart within."—Chapman.

Dr. ANDERSON was born in the city of New York in the year 1798. His father and mother, DAVID and GERTRUDE ANDERSON, soon after his birth, moved into the country, and resided on the borders of New York and New Jersey. He has had seven brothers and one sister, JOHN, GANOT, JAMES, DAVID, DANIEL, WILLIAM, MALVINA, and HENRY. In 1814 his parents returned to the city, and he has ever since, with brief intervals, made it his residence. During his rural sojourn he attended country schools, and in 1815 and 1816 became a pupil in the excellent grammar school of the blind teacher, JOSEPH ACTSON, LL.D., in Franklin street, who subsequently became Professor of Latin and Greek in RUTGERS' College, New Brunswick, New Jersey. In 1817 his father moved, with the rest of the family, to Illinois, while he remained in New York, being at that time nineteen years of age, and began to turn his attention to his future pursuit, which was that of a Doctor of Medicine. He did not follow any collegiate course at this time, nor was he graduated from any academical institution; but, being rather delicate in health, passed much of his leisure in active out-door exercise, both on land and water. This weakness of constitution was the result of an alarming attack of summer complaint, when he was an infant, which emaciated him to such an extent that the convulsions of his intestines were visible, and for a time he was given up. During the winter of 1813-14, from over-exposure to cold while walking four or five miles through mountain passes which were covered with snow, he over-fatigued himself, and was prostrated with typhus fever, at that time very prevalent. In the fall of 1826 he also became dangerously ill from bilious fever, which he contracted while

attending a patient who was ill at Elizabeth Town, New Jersey; where the Doctor was obliged to stay over night two or three times a week. Chill and fever troubled him after this for some two or three years. Though the victim of so many attacks when young, since that period the Doctor's health has been so very excellent that he has not been confined to the house from illness twenty consecutive hours, with the exception of an accident which injured the lumbar region, and resulted in spinal meningitis. He was rapidly relieved by the judicious application of leeches, cups, blisters, and was only compelled to remain at home five days.

The Doctor never entered into any other pursuit than that of a physician, and, after following out the prescribed course, was formally graduated M. D. from the College of Physicians and Surgeons in 1820. His Thesis was on Neuralgia, and he pursued his course of medical studies under the guidance of RICHARD S. KISSAM, M. D., at that time Surgeon to the New York Hospital, whose office he entered, and in time became his principal assistant in surgical operations. After remaining with Dr. KISSAM two years, he entered the office of DAVID L. HOSACK, M. D., LL.D., Professor of the Theory and Practice of Medicine, and Physician to the New York Hospital. Soon after receiving his diploma Dr. Hosack obtained for Dr. ANDERSON the appointment of Surgeon to accompany the West Point cadets, under the command of Colonel NORTH, while on an excursion to Philadelphia, and gave him a letter of introduction to Dr. HORNER, Professor of Anatomy. Dr. ANDERSON went with the company, but did not present his "letter," owing to the distance of the encampment from the Doctor's residence,*

* As the following notes explain a fact in the life of the distinguished Dr. HOSACK, I take the liberty of publishing them for future reference:

"NEW YORK, August 15th, 1820.

"My Dear Anderson: I enclose a letter for you to Dr. HORNER, the Teacher of Anatomy in the College of Philadelphia. I wish you to see his collections, and examine them with great care, for I shall probably have you attached to my office. I have closed my engagement with Dr. FRANCIS. Do find out the state of the city, and write to me, that I may communicate your information to the Board of Health.

"In haste, yours,

"D. HOSACK.

"Call on Dr. HORNER as soon as possible."

"NEW YORK, August 15th, 1820.

"Dear Sir: Doctor ANDERSON, a pupil of mine, and graduate of our college, is in Philadelphia, and he is particularly attached to anatomy, and has made for me many valuable anatomical preparations, and is likely to be eminent in that branch of professional knowledge, in connection with surgery. I beg leave to introduce him to your acquaintance, and ask the favor of you to give him an opportunity of seeing your valuable collections. He is young, and has had no opportunity of seeing col-

and the shortness of his stay. In the fall of 1820 he was engaged by Dr. HOSACK to take charge of his office, and private class of students, and examined them daily in anatomy, surgery, dissecting, and making anatomical preparations, some of which are still in existence. Recent improvements in the art of injecting the arteries, and the many beautiful plates, now open to the inspection of all, have rendered the preparation of specimens much easier than it was formerly.

For three years Dr. ANDERSON continued to instruct this private class of medical students, which numbered from twenty-five to forty at different times. He also made a similar arrangement with Dr. JOHN W. FRANCIS, Professor of Obstetrics, and continued with him over three years from the time his connection with Dr. HOSACK ceased. Some of the anatomical preparations made at this time, under his special supervision, are now to be found in the Geneva College Museum. He likewise maintained the deepest interest in RUGGERS' College anatomical preparations, under Professor GODMAN, and, after his death, with Dr. BUSHE, "when," to use his own words, addressed to me on the subject, "the College was shut by the continued persecutions of legislative laws." After this he confined himself strictly to private practice, not even taking rest enough to venture abroad, having resided in the city of New York since 1822.

In 1829 he formed a connection with Dr. BUSHE, not infrequently being left in charge of the Doctor's patients during his absence from town. On these occasions Dr. ANDERSON did not confine himself to the medical treatment of disease, but performed, with gratifying results, operations for hernia, popliteal aneurism, removal of tumors, and various amputations.

In the spring of 1822, he married Miss E. C. ANTHONY, of New York, and was blest with four children, one of whom, a son of praiseworthy steadiness, is now relieving his father of the over cares of a large practice, and assuming the responsibilities of the medical profession.

On asking Dr. ANDERSON his opinion of the prevalence of smoking, he replied as follows: "I do not smoke, except at the St. Nicholas Dinner, when I take three or four puffs of the long pipe.

lections on a scale you possess. Your attention to him therefore will be peculiarly grateful to him, and will confer a favor upon me. You will find him intelligent, and adroit with his knife and syringe, and on these accounts I am sure you will give him an opportunity of seeing the details of your anatomical laboratory. I hope to have the pleasure of seeing you in New York, and of personally acknowledging the favors I have received from you.

"Very truly, yours, in haste,

"D. HOSACK.

"Dr. HORNER, Professor of Anatomy."

I could never learn when a boy. It is a *dirty* and *filthy* practice; has no good effect, but evil continually. No man, who is the subject of dirty and filthy habits, can be a gentleman. The definition of the latter term is very indefinable. No so powerful a drug can be used with impunity, no more than arsenic or opium."

With regard to any favorite branch of practice, the Doctor at first paid more attention to surgery, though not to the extent of a specialty, pursuing what is known as a general practice; treating, however, those cases of a surgical character that came under his immediate inspection.

The Doctor's height is 5 feet, 9 inches, and his weight, for the last forty years, varying from 145 to 150 pounds. His appearance is that of a thin, healthy man, with a florid complexion and clear eye.

He was brought up in the Protestant Reformed Dutch faith, which came over here in company with "our good old Holland fathers," and has been a member of that church over forty years. To use his own words, in reply to my question on the subject, "My faith and doctrines are to be found in the old Heidelberg Catechism, which is a very able exponent of the doctrines of salvation as taken from the Bible."

The Doctor has not written much, preferring to read rather than make books; but a few emanations from his brain may be recorded, of which we find the following:

1. Case of Neuralgia.
2. " " Albuminuria.
3. " " Delirium Tremens. Published in N. Y. Academy of Medicine Bulletin for 1860.
4. Inaugural Address before the New York Academy of Medicine.
5. Address before the American Medical Association, as Chairman of the Committee of Arrangements.*

On asking him if he would be a Doctor again, he replied, "I have no reason to be dissatisfied with the profession. I have worked hard, and God has prospered me. I hope I have many friends, and but few enemies. I feel proud of the profession. It is second to no other, and in many respects above, in moral influence, owing to the peculiar relations to society. As a whole, there is a high morale. In a business point of view, it is sure of success, under proper directions and energy."

Dr. ANDERSON has been a member of the Executive Committee of the New York Academy of Medicine, one of the Corporators in the Board of

Trustees; Vice-President several years; and has been elected President of the New York Academy of Medicine three consecutive terms of two years each. This last honor speaks well for the satisfactory manner in which the Doctor has presided. During his administration, the Academy has seen some of its most exciting times. To briefly mention a few of the disturbing elements, memory can call up the GREENE and WHITNEY case, swill-milk discussions, politics versus medicine during the commencement of the rebellion, etc. Truly one may say that, in looking over the bulletin for the past six years, papers have been read, of the most vital interest; experiments of an original character explained, and theories based on experience unfolded by the profession, that constitute an epoch in the progress of that science.

Dr. ANDERSON was one of the Board of Managers of the Society for the Relief of Widows and Orphans of Medical Men sixteen to seventeen years; Vice-President eight years, and President three years. Member of the Council of Hygiene and Public Health of the Citizens' Association, since its organization, and a member of the Beneficent Board of the Reformed Dutch Church, Missionary Society, Sabbath School, and Publication Board nearly thirty years.

Dr. ANDERSON has done much to keep up a kindly fellowship among the members of the Academy of Medicine. His receptions during the winter are composed of the best part of the medical profession, and his kind and hospitable manner has accomplished much in reconciling prejudices. Through his exertions a complete list of cabinet photographs of all the Presidents of the New York Academy of Medicine have been procured, together with a new volume for the signatures of recently-elected "Fellows."

There are those still living who remember the alacrity with which "young ANDERSON" went forth, after the manner of "Cruncher," in company with some six medical students, to procure a body for the use of Prof. GODMAN, at the time Dr. ANDERSON was his demonstrator. Not a few have praised his daring in endeavoring to dig up a body in Potter's Field, while others of his party called on the keeper and endeavored to arrest his attention while they continued their labors. Memory also laughs over the roused suspicion of the keeper and his son; the sudden accelerated ejection of the two callers at midnight; their chase by bull-dogs, and sudden secretion in the company of five hundred hogs; as though, like evil spirits, they had been cast into the swine; and the return of the disappointed party! Gratifying is it, in-

* See Transactions for 1864.

deed, to know that at the present time a few dollars will procure cadaverous facilities and immunity from punishment.

**NITRO-MURIATIC ACID AND STRYCHNIA
IN CEREBRO-SPINAL MENINGITIS,
(SPOTTED FEVER.)**

By SAMUEL M. HARRY, M. D.,

Of Maryland.

Two cases of spotted fever having occurred in my practice since May 1st, 1866, I have concluded to give you the history of each, the treatment, and the final result; also some other affections in which I have found the above remedy very efficacious.

On May 1st, 1866, was called to see the daughter of W. J., aged $4\frac{1}{2}$ years; found her with high fever, quick pulse, flushed face, and great restlessness, so much so, that she could not be retained in one position two minutes at a time, and calling out continually, "O My!" Her mother said she had not been well the day previous, but was still up and down; that in the night she had a chill, and then the fever came on; her bowels had not been moved. I gave her a powder of calomel, rhubarb, and ipecac., to be followed with oil and turpentine; left a mixture of chlorate of potassa and ipecac., in the form of a tea, to be given every two or three hours during the fever; cold to the head, mustard to the back of the neck, as she complained very much of her head, particularly the back part. The next morning found her in the same restless condition, the entire body covered with copper-colored spots; her pulse quick, but feeble, her mouth and tongue dry, and the same tossing from side to side, and the occasional "O My!" I then gave her calomel, quinia, chlorate of potassa, syrup of iodide of iron, brandy and milk, broths, etc.; and as there was a peculiar hoarseness when she cried, I gave a mixture of syrup of squills, and verat. viride. Small pieces of ice, hot applications to the spine, frequent bathing of the whole body with warm soda water and whiskey, blister to the back of the neck. The syrup of iodide of iron I gave in full doses, and continued it regularly until the last day of her sickness; the other remedies were used as the case seemed to require. I mention them so that you can see that we resorted to all that have been recommended by the best authors on the subject; but with all, she died on the evening of the 9th, having been sick nine days, and under treatment eight days.

During her entire sickness she complained of great soreness of the whole body, crying out whenever she was taken up or moved. The head was

drawn back, requiring the pillow to be placed under the neck rather than the head. The eruption continued out all the time (even after death several hours), sometimes not so distinct as at others. On the night of the sixth day, so great was her distress, I gave her some opium in one of her powders of calomel, chlorate of potassa, and ipecac., after which she became quiet, and slept several hours; she afterward took two more of the same kind, but they did not seem to be any benefit to her. Such is the history of the first case.

In a few days after I was called to see a boy nine years old, of delicate constitution, in a house about one hundred yards from the residence of the first case. The symptoms were much the same as the first, and I feared the result several times. While reading the history and treatment of spotted fever in the *REPORTER*, I thought that strychnia and nitro-muriatic acid might be beneficial in such cases. I had confidence in them when I had the first case, but felt reluctant about trying the experiment, but here was another case in so short a time, and how many more would follow, were facts and questions that settled in my mind the propriety of giving them a trial, as I remembered too well my success with the other treatment. I immediately gave a powder of calomel, rhubarb, and ipecac., followed by the oil and turpentine, to open the bowels, and then used the following:

R. Strychniæ,	gr. j.	
Acid. nitro-muriat.,	f. ʒj.	
Aquæ,	f. ʒij.	M.

Ft. sol. S. Half a teaspoonful every five hours in sweetened water, with orange or lemon juice added, to cover the taste.

That was the only medicine I gave internally, with the exception of repeating the oil and turpentine to keep the bowels open when they required it, for two weeks, at which time the boy was able to go down stairs.

Externally, I used hot spirits of turpentine along the spine every few hours, blister to the back of the neck, and had him rubbed all over twice a day with one part spirits of turpentine, and two parts cod liver oil (*mixed*), sponging the whole body with warm soda water before each application; at the same time giving him broths, brandy and milk, etc.

This case had as serious symptoms in every respect as the first; the eruption was similar, the soreness and drawing of the head very much the same, and, in fact, the great restlessness and misery seemed more distressing for the first forty-eight hours, after which he gradually became more quiet.

On the third day he had quite a bleeding at the nose, and on the fourth vomited up a large amount of blood, his parents said. Still I continued the treatment, giving it only every six hours, at the suggestion of Dr. C. S. SIMPERS (who I had, on the third day of the case, called in consultation), and who, by the way, had seen and treated, at Camp Parole, Md., quite a number of cases, as he assured me, of the same kind, but not with the same remedies.

His convalescence was rapid, and without any drawback. Such is the history of the second case, and thank fortune, there have been none others to test it on since; if there had, I should have used the same remedy again and again.

In regard to other affections, such as chronic diarrhoea, summer complaint of children (with tinct. opii.), low stages of any of the fevers, dysentery, and finally, in that prostrate condition of the system from over-exertion and indigestion of long standing, it is most valuable. For a broken down doctor, too, I can bear testimony as to its efficacy, for I have been using it, in the proportion of one-sixteenth grain strychnia, and five drops nitro-muriatic acid, in water, three times daily, at times, for four months, and have been very much benefited.

PNEUMONITIS, COMPLICATED WITH PLEURISY

On both sides of the Chest, in a Child of Eighteen Months; rapid convalescence.

BY SAMUEL PAGE, M. D.,

Of Jackson, California.

April 12th. Saw the patient, with what we would term a cold or bronchial catarrh, attended with little or no fever. The prominent symptom was mucus roncus, mostly in right lung; an emetic gave exit to large quantities of mucus, followed by marked relief. Vesicular murmur was quite distinct throughout the lungs.

April 13th. Thought the child so much better that no medicine was ordered. No examination of chest was made; the gums were incised to insure no irritation from this source, some of the anterior bicuspid having just appeared, and the gums much swollen over the rest.

April 14th. Was summoned to see the child, and found it quite feverish, with increased cough, and inspirations 50 to 60 per minute. Alterant and nauseant ordered.

April 15th. Found the child worse, emetic and nauseant doses of antim. tart. were administered.

April 16th. At midnight, found bronchial respiration in inferior lobe of right lung, also pleu-

ral friction at same site, and mucus roncus in other parts of the lung. Cough suppressed, the patient showed great anxiety, inspiration quickened, crying at prolonged intervals, attended with constant motion of right arm and leg; its decubitus not marked. After apparent exhaustion it would appear to rest for a few moments; pulse 140. Skin generally not above the natural standard of temperature through the course of the disease.

About noon of the 17th one leech was applied in the right infra scapular region, and bleeding encouraged for some three hours; child slept, and the skin was bathed in perspiration. Inspirations 40 to 50, and quiet breathing. The cough, from little or none, became quite persistent at intervals, proving effectual, as the child swallowed after coughing.

April 18th. Eleven o'clock at night the patient commenced moaning and whining, which was continued till five o'clock in the morning of the 19th, when it commenced crying, not a peevish cry, but screeching at the top of its voice, and continued for two hours throwing itself in all positions imaginable, head, arms, and legs, in continual motion, no position or place could be found to pacify it, countenance depicted the most intense suffering; eyes appeared fixed; objects were not noticed while in these paroxysms. Inspirations 60, short and intermittent, and pulse slightly so, with beats of 140 to 160 per minute.

In conjunction with Dr. MILLS, on examination of the chest, bronchial respiration was found in the anterior part of the left lung, and not the least rale in this part, but in posterior or scapular region, some mucous rale, during the time of three minutes, the time of auscultation, also pleural friction was detected; this was about 11 o'clock, A. M.; about 4 o'clock, P. M., three leeches were applied on the infra scapular region of left lung, and bleeding encouraged for two hours. The paroxysms of suffering, which had continued at intervals of fifteen to thirty minutes, were modified, and the child slept about one hour, but not soundly. One marked condition of our patient during the day was the extreme exaltation of the nervous system, the least step on the floor, jar of a door, or touch of the bed-clothes, or itself, would throw it into a paroxysm of suffering, and this condition lasted during the most of the 20th, before the bleeding ceased. The patient perspired, looked pale, and gaped several times, but still the pulse remained persistent, and the paroxysms of suffering increased again, and continued all night at regular intervals, and terminated only at times when the

child could cry no longer. Skin cool, finger-nails and lips purple, frequent intermissions of respiration, so much so that the grandfather thought it was dead several times, and so told the parents, notwithstanding the assurance I gave him to the contrary. About 11 o'clock, P. M., effusion was detected in the left pleura, by succussion and bulging of the intercostal space, as witnessed by Dr. MILLS and myself. Six hours after we could not detect any water in the pleura; at this time the child was suffering so much the chest was enveloped with a mustard cataplasm, followed by immediate relief for about half an hour, but the pain returned again, and the mustard did not give so marked relief. Our patient at time of effusion, until about 8 o'clock of the morning of the 20th, was as the flickering light—a touch would extinguish—hardly an audible cry—feeble effort of limbs, cough almost entirely suppressed, urine stained linen yellow, and very scant for the last two days. As expectorant, fl. ext. of senega, wine of ipecac, and syrup squills, for the same length of time. For the 19th, s. s. nitre in 10 to 20 drop-doses every three hours, also DOVER'S powder and calomel, from a fifth, increased to three grains of the former to one grain of the latter, every three hours; the larger dose was given twice with favorable results, as the delirious paroxysms were very much modified. At 8 o'clock, A. M., of the 20th, gave ol. ricini, f. 3ij., and fl. ext. mandrake, gtt., iij. At 4 o'clock, P. M., took the first sound sleep in its father's arms, to whom he would not go before. He lay upon his back, head hanging down, arms extended, one placed on a chair, and one held by myself; slept about two hours, bowels moved freely at 7 o'clock, P. M.; soon followed by second motion. Cough commenced about 10 o'clock, A. M., and grew more persistent at intervals, until it cleared its lungs in three or four days; the cough appeared to be his main trouble at this time, as he would cry at every paroxysm, before and after. On the 20th and 21st diuresis was established; the tongue commenced cleaning, and convalescence was inaugurated; no more medicine was given, except an injection on the 24th, and an aperient a short time after. On the 26th could walk about again, and had but a slight, hacking cough, and he was soon as well as ever.

The points of interest to me are the cerebral symptoms, pleurisy, intermittent pulse, and the general cool condition of the skin, so much so, that the question might arise, did pneumonitis exist? If we had not had marked dulness on percussion, and bronchial breathing, without the

least moist rale, when the examination was made on the 19th, at 11 o'clock, A. M., in anterior lateral portions of left lung, and so marked a stage of resolution by the quantity coughed up and swallowed, we might say no—otherwise as we have decided.

Parents healthy, over medium height, with a nervo-vital temperament. Lost two children with a similar disease, one at the age of ten months, and the other two and a half years. There remain one daughter, now aged twelve years, and the subject of our sketch.

Hospital Reports.

LONG ISLAND COLLEGE HOSPITAL, }
Session, 1866. }

CLINIC OF PROFESSOR E. N. CHAPMAN.

Reported by Alex. J. C. Skene, M. D., Clinical Assistant to the Chair of Obstetrics.

Abnormal Labor requiring Forceps Delivery.

History and Treatment. Annie D., aged 23, a strong healthy woman, was admitted into the hospital, March 13th, in her first pregnancy. Premonitory pains took place on the evening of the 17th, and continued until after midnight, but there was no dilatation of the os uteri produced by them. It was now deemed advisable to give an anodyne to arrest the pains which, doing no good, were likely to exhaust the patient. It was also expected that, whilst rest gave renewed strength to the patient, the uterine neck would become more dilatate. Prescribed

R. Pulv. opii, gr. iij.
Pulv. camph., gr. ss. M.

Ft. cht. No. j.

Sig. To be taken directly.

The patient soon went to sleep, and had no further trouble until the next night, when the pains returned and the os uteri began to dilate slowly. On the morning of the 19th, the bowels were moved freely by an enema, after which the pains became stronger. The progress then was favorable, and by eleven o'clock the os was fully dilated. The membranes, which had accomplished their work, were now ruptured.

The vertex presenting in the first position, and the expulsive force being good, the head soon settled down in the oblique diameter of the pelvis. Rotation was looked for every moment, and it was expected that the labor would soon terminate, but the head remained fixed, without making the slightest progress or change in its position, though the uterine contractions and bearing-down efforts of the mother were remarkably strong.

After waiting for some time, an examination was made with the view of discovering the cause of the delay. It was found that the spines of the ischii were preternaturally long and projected into the pelvic cavity to an abnormal extent, and that the frontal portion of the child's head could

not pass down between the promontory of the sacrum and the spine of the ischium on the right side. This spine impinging on the child's head, near the right temple, effectually prevented rotation. Otherwise the pelvis was ample.

Some further time was spent in waiting, with the hope that possibly the obstruction might be overcome by the efforts of nature, but no progress was made. The pains, which had been powerful, began to subside, and the patient became discouraged and exhausted.

At 7 o'clock on the 19th, the patient was placed under the influence of an anæsthetic, composed of three parts of ether and one of chloroform, and delivered by forceps.

Some difficulty was experienced in applying the right-hand blade of the forceps, owing to the head being pressed against the spine of the right ischium, but when the forceps was adjusted, the extraction was very easy. After delivery, there was observed on the right temple a wound in the integument and a depression in the bone corresponding in size and shape to the spine of the ischium. Nothing further of interest occurred in the case; the mother and child did well, and left the hospital on the 28th of March.

Commentary. This case illustrates a class of difficult labors often requiring instrumental assistance from a cause which, though not very uncommon, is not very fully treated of in works on obstetrics. When the head descends into the pelvis in the right or left anterior position, it occupies one of the oblique diameters until the head, settling down to the spine of the ischium, slides past it posteriorly into the hollow of the sacrum. At the same time the vertex glides down the anterior plane of the left side from the acetabulum to the pubic arch, at which time rotation is completed. Now it will be readily seen that if the spine of the ischium projects into the pelvic space to any great extent, or even as much as is normal in the male, the head will meet with an obstruction to its rotation, and consequently will be arrested. The diagnosis can generally be made without difficulty, from the fact that the labor, progressing favorably until this point is reached, then becomes completely arrested. The projecting spine, with the head pressing against it, can be observed by the touch. At all other points ample space is found between the child's head and the mother's bones.

It is not proper in such cases to use ergot, but rather to apply the forceps, by whose aid the labor can generally be readily completed.

Inertia of the Uterus. Instrumental Delivery.

History and Treatment. Amelia L., aged 28, in her first pregnancy, was admitted into the hospital May 7th. She was of delicate constitution. About the middle of the afternoon of May 24th, a slight show manifested itself, attended with erratic premonitory pains, which continued until midnight, when they became more uniform in character.

Towards 4 o'clock the following morning, the pains assumed a truly expulsive character, and the os uteri, which had been gradually relaxing, was fully dilated. The membranes ruptured spontaneously, and the pains continued to recur

regularly, but did not continue long at a time. The patient made the best use of her pains by bearing down and voluntary efforts.

The head of the child presented in the left occipito-anterior position, and was in normal proportion to the pelvis of the mother. It engaged in the superior strait, and very slowly made partial descent and rotation, but no further progress was made, though the pains continued. At 9 o'clock, the pains became weaker and of shorter duration, and the patient complained of exhaustion.

The most careful examination revealed no mechanical obstruction to the progress of the labor, yet there was not the slightest advancement. The walls of the uterus were very thin, as manifested by the angularities of the child being perceptible through the abdominal parietes, in the absence of the pains. Stimulants in small doses were given with the view of increasing the expulsive efforts, but without effect. The pains became less energetic, and by 11 o'clock, had almost entirely subsided. She continued restless and uneasy for about two hours, having only an occasional slight pain, resembling in character those of the first stage of labor. Having waited for that length of time, it was considered highly improbable that the labor would terminate normally, consequently, it was decided to deliver by forceps.

An anæsthetic, consisting of two-thirds of sulphuric ether and one of chloroform, was administered, and a careful examination made in order to confirm the diagnosis regarding the position. By carrying the finger high up along the side of the head, the ear could be plainly felt, which left no doubt that the child presented in the first position. The meconium came away in large quantities during the examination, as it had done since the os uteri was fully dilated, an occurrence not common in vertex cases.

The forceps were applied without trouble, and very little tractive force was required to terminate the delivery. Considerable hemorrhage followed, owing to the uterus not contracting with much power. The placenta was removed by friction over the abdomen, when the flow ceased.

The mother and child both did well, and left the hospital at the end of three weeks.

Commentary. In this case nature was incompetent to complete the process of parturition, through inertia of the muscular walls of the uterus, and consequently assistance was necessary. This want of power on the part of the uterus may be due either to a want of nerve-power in the uterus, or imperfect muscular development. In each case the effect on the labor is the same, but in treating it we must make a distinction. In a case like this, where the walls of the uterus are very thin, as shown by the facility with which the child's knees and elbows are felt, there is evidently a want of muscular power.

This want of power is supplied by the forceps; whereas, when the uterus is well developed, but inactive, ergot will bring out its latent powers, and is indicated in those cases where we lack simple uterine force, and we are certain that the

labor can be completed in an hour. But ergot should not be used, however, simply because there is inertia of the uterus, until you are satisfied that it is sufficient to accomplish the delivery safely to the mother and child. In some cases there is difficulty in deciding which to use, ergot or the forceps, but, as a rule, the forceps is to be preferred whenever there is a doubt. Those who are adepts in the use of the forceps prefer them in all cases when delivery is practicable by their aid; whereas, those who are less skilled in their application are forced to use ergot. The accomplished obstetrician, having an equal command of both, will use the one which gives the best chance of success in each case as it comes under his care.

Difficult Labor.

History and Treatment. Bridget M., aged 20, a very strong, robust person, in her second pregnancy, was taken in labor early on the morning of the 22d of June. The case progressed rapidly and favorably, and by 9 o'clock the os was fully dilated. The head presented in the first position. The expulsive pains becoming strong, and being almost continuous, the head soon engaged fully in the oblique diameter, but made no further progress. The pains continued very strong until 12 o'clock, when they grew more feeble, and from the intense suffering, the patient became unmanageable.

She was placed partially under an anæsthetic for the purpose of easing her suffering, and to facilitate making a thorough examination to see if any obstruction to the labor existed, and, if necessary, to deliver her with the forceps. The head was found to impinge on the spine of the ischium, which was abnormally prominent. More profound anæsthesia was produced, and the peristaltic action of the uterus increasing, rotation rapidly took place, and the child was born in a few minutes.

The child had a mark on the right temple, produced by the pressure on the spine of the ischium. Nothing further of interest occurred in the case.

Commentary. The fact that this case was in labor for three hours without making the slightest appreciable progress, and then by a sudden change terminating in a few moments, shows that the head must have met some fixed obstruction, which, from the peculiar mark on the temple, doubtless was the spine of the ischium.

Either, when given in labor, whilst it arrests the voluntary expulsive efforts, increases the peristaltic action of the uterus, and thereby facilitates the progress of labor in many cases. This case exemplifies this point; the stimulus given to the flagging action of the uterus was sufficient to overcome the obstruction which had successfully resisted the unaided efforts of nature.

Labor in a Case with Congenital Narrowing of the Vulva.

History and Treatment. Ellen C., aged 25, a robust woman in her first pregnancy, was brought to the hospital at 4 o'clock, A. M., July 1st. She had symptoms of labor, and, on examination, it was found that the os was dilated to the extent of

an inch in diameter. The introitus vulvæ was observed to be abnormally small, its longest diameter being, at most, only an inch. The nymphæ were rudimentary, and the labiæ majora, imperfectly developed, were united anteriorly and posteriorly by folds of integument that narrowed the genital fissure, and left but a small opening, having neither the size nor the shape of the normal vulva. Everything in other respects promised a favorable issue, and it was considered best to wait until the head distended the perineum before any interference was made. The case progressed normally, and about 1 o'clock, P. M., the head distended the perineum. All necessary preparations being made to enlarge, by incision, the vulva, time was allowed for the head to dilate and distend the perineum as much as was deemed safe.

It soon became apparent that the genital fissure was too small to admit a segment of the head sufficient to produce its dilatation. There was no tendency to laceration, or even stretching of either the anterior or posterior commissure, but, on the contrary, the head carried the whole perineum before it. At this stage the vulva measured no more than an inch and a half in its longest diameter.

A probe-pointed knife was introduced on the finger between the head and perineum, and an incision, two and a half inches long, made posteriorly, and a similar one anteriorly, about one inch in length in each direction. The delivery terminated with no further trouble. When the incisions healed, the perineum was found to measure one inch and a quarter, and the vulva presented a normal appearance, excepting that the labia minora were scarcely perceptible, and the labia majora were not prominent. Patient and child left the hospital July 13th.

Commentary. Cases like this are not common, yet several have been recorded. There is one in which the head was forced through a laceration in the perineum. It might be presumed that in such instances laceration of the posterior commissure would take place, and that nature would thus terminate the delivery without surgical interference, but when we consider that in such deformities the opening is high up near the pubes, where the pressure of the head is least powerful, and the vulva is so small that the head cannot wedge into it, we see plainly that there is very little tendency to spontaneous enlargement by laceration. In this case it appeared as if the soft parts of the pelvic outlet would be torn through before laceration would take place at the vulva. If such cases were left to themselves the result would be disastrous, but fortunately the treatment is simple and effectual.

In such cases we believe the best practice is to let the head distend the perineum fully before enlarging the vulvar orifice, because the length required at this time can be more accurately determined. The perineum should be carefully supported, and the progress of the head restrained if it tends to advance too rapidly. If this is neglected there is great danger that the perineum will be torn at the point of incision.

Medical and Surgical Reporter.

S. W. BUTLER, M.D., Editor and Proprietor.

PHILADELPHIA, SEPTEMBER 8, 1866.

THE CHOLERA.

The past week has been marked by a decided subsidence of this disease in all parts of the country. It has prevailed with the greatest severity in some of the western cities, as Cincinnati, St. Louis, Chicago, and Memphis, but the reports have dwindled down to but a few cases daily, and scarcely any deaths. But very few cases are reported in New York and Brooklyn. The cities of Boston, Baltimore, and Washington have seemed to be remarkably exempt from the disease, and indeed south of Philadelphia we have only a few cases reported from Richmond and New Orleans to record—the other southern cities being almost entirely exempt from the disease.

In this city the epidemic did not attain much power. Our last report was to the week ending July 28th, the total number of deaths to that date being 33. The following has been the mortality since that time;—week ending

August 4th,	47
" 11th,	52
" 18th,	56
" 25th,	91
September 1st,	58

Of the whole number, 165, or 49.22 per cent., occurred in the wards supplied with water from the Kensington works. The deaths in that section of the city were as follows: Sixteenth Ward, 11; Seventeenth Ward, 31; Eighteenth Ward, 62; Nineteenth Ward, 46; Twenty-third Ward, 1; and Twenty-fifth Ward, 14.

The natiivities of the deceased were: United States, 156; foreigners, 137; unknown, 42;—total, 335.

The sexes, etc., of the deceased were as follows:

Week ending	Male.	Female.	Adult.	Children
July 14,	1	2	3	—
" 21,	6	4	9	1
" 28,	7	11	16	2
Aug. 4,	28	19	38	9
" 11,	14	38	43	9
" 18,	31	25	51	5
" 25,	46	45	72	19
Sept. 1,	24	34	51	7
	157	178	283	52

Notes and Comments.

"How Shall I Treat Chorea?"

In reply to this question, asked by a correspondent, (REPORTER, p. 179, Aug. 25th,) Dr. IRA DAY, of Mechanicsburg, Pa., writes: "After preparing the system properly, give FOWLER'S solution of arsenic, from five to ten drops three times a day, till the constitutional effect is manifested; then desist for a few days. Repeat *pro re nata*, and you will cure nine out of every ten cases."

Dr. FLINT L. KEYES, of Jerseyville, Canada West, advises a mercurial purge, followed by quinia and aloetic laxatives, a plain nutritious diet, giving due attention, in young girls, to the condition of the menstrual function.

Dr. E. A. OPPELT, of Tuscarawas, Ohio, writes: "I cured two cases of chorea with *cimicifuga*, after trying various other remedies unsuccessfully. The one was a single lady of seventeen, and the other a girl of twelve. Both were of a rheumatic diathesis. The elder had diphtheria at the time she took chorea; the younger had had the diphtheria some three weeks before.

"I obtained some fresh roots of *cimicifuga*, and bruised them well and put them into a vessel, and put twice as much water on it as I had of the roots, and boiled down one-half. I then added one-fourth as much of alcohol, (after straining,) and sweetened it well with sugar, and administered from half to a tablespoonful every six hours, and in about two weeks my patients began to improve. In six weeks they were entirely well, and have never had any symptom of the disease since.

"Amongst the remedies that I tried in the younger of my patients, was HALL'S solution of strychnia, which aggravated the disease very much, and, I believe, would have proved fatal with the ordinary dose, had I continued with it.

"I took the above way of preparing the medicine, because I had none of the tincture on hand, and did not wish to wait until I could get some, as I lived twelve miles from a drug store then. Let your correspondent put aside all other remedies, give the above treatment a trial for six weeks, and report if he is unsuccessful with it."

ERRATA.—In Dr. BANNING'S article in the REPORTER for Aug. 25th, p. 172, second column, 6th line from bottom, for collapsed read prolapsed. P. 173, second column, last line of first paragraph, for abdominal read uterine. P. 174, first column, line 12 from bottom, for intensus read relaxes. P. 175, first column, lines 18 and 19 from top, for primaria read primæ viæ.

Diphtheria.

Dr. C. V. MOORE, of Stillwater, N. J., writes as follows:

"I have recently had two severe cases of diphtheria. In one the disease had invaded the larynx, causing loss of voice, croupy cough, and paroxysmal attacks of suffocation and respiration. Both cases were promptly relieved, and cured simply by the internal administration of small and oft-repeated doses of permanganate of potassa, and the inhalation of vapor of slacking lime. The relief from the inhalation was very marked, and the result was gratifying, both to the little sufferer, the friends, and most assuredly to the attending physician. These two cases were sporadic. Perhaps, if the disease should prevail as an epidemic, the results would not be as satisfactory. The only external application that I am satisfied with is the camphor poultice, which gives comfort to the little patient when there is much external swelling. The poultice is prepared by taking a tablespoonful of wheat flour, a little sweet milk, 20 grs. salæratum, and sufficient spirits of camphor to make it the consistence of thick paste.

"In the treatment of the disease I avoid all depressing agents, and give freely milk and beef tea."

Books and Pamphlets Received.

On Spermatorrhœa: Its Causes, Symptoms, Pathology, Prognosis, Diagnosis, and Treatment. By ROBERTS BARTHOLOW, etc. etc. From WM. WOOD & Co., New York.

On Asiatic Cholera. By JOHN C. PETERS, M. D. From D. VAN NOSTRAND, New York.

Epidemic Cholera: Its Pathology and Treatment. By A. B. PALMER, M. D. Reprinted from the *Detroit Review of Medicine and Pharmacy.* From the Author.

Memorial Address. DAVID S. CONANT, M. D. Delivered to the Graduating Class in the Medical Department, University of Vermont. By A. B. CROSBY, A. M., M. D. From the Author.

Whisky and Tobacco: Their Effects upon Soldiers and others. By PAUL F. EVE, M. D., Professor of Surgery in the University of Nashville. From the Author.

Annual Report by the City Registrar of the Births, Marriages, and Deaths in the City of Boston. N. A. APFOLONIO.

Transactions of the Medical Society of New Jersey for 1866. Centennial meeting.

Transactions of the Vermont Medical Society for the year 1865.

Correspondence.

FOREIGN.

The Kommune Hospital, Copenhagen.

COPENHAGEN, DENMARK, July 31st, 1866.

EDITOR MEDICAL AND SURGICAL REPORTER:

I visited yesterday the Kommune Hospital, for two thousand patients, in Copenhagen. It is situated on Osterbro street, at one extremity of the Hospital Kod. I was unable to speak Danish, but by direction of Surgeon BERG, of the Frederik Hospital, and the assistance of an interpreter in the person of a clerk of the American Consul, I was enabled to see many things of interest. Kommune Hospital is new, and is one of the finest hospitals in Europe: It is situated in the suburbs northwest of the city, and is reached by a road through extensive public pleasure gardens. On first sight, it appears like a large country hotel in the midst of a well kept park of five hundred acres. It consists of a main building with two wings, also a variola hospital, a fever hospital, a large building for the steam-engine, a laundry, bath-house, kitchen, and surgeon's house. The medical inspector kindly directed Mr. KORNRIEP, one of the resident surgeons, to show me about the building.

The plan carried out is that of dividing each of the three stories into rooms sixty feet square and fifteen feet high, each room containing twelve patients. Floors covered with shellac; no matting; white walls. The bedsteads are of iron, arranged so as to be changed into a fracture-bed, by lowering head and foot pieces. The beds are well made, thick hair mattresses, sheets, white coverlids or blankets, and good pillows.

The ventilation of the rooms and halls appears to be on a complete plan, it being effected by means of fans driven by the steam-engine in the rear of the hospital proper. The air is forced through pipes into the reservoir situated in every hall, and from the reservoir the air is carried through flues to registers situated in the top of the four walls of the room. At intervals of a yard, in the base boards of the room, are openings of parallelogram shape, for the purpose of allowing the foul air to pass out. My informant states the system of ventilation works admirably.

Over the main entrance is the dome containing the chapel. In this main part is a dumb-waiter, fifteen feet long by ten feet wide, elevated and lowered by machinery. A carriage, containing the sick or injured man, is driven up to the side of the dumb-waiter, the man or woman is ex-

amined, cleansed, and dressed in the reception rooms adjoining, placed on his bed on the dumb-waiter, the lever is moved, and patient and attendants go up together. Upon the second and third floors are three-wheeled vehicles, fitted to receive the patient and his bed, the vehicle is then propelled by hand into the room assigned for the patient. The floors are evenly smoothly laid with narrow deal planks; the doors to the rooms have no sills; thus all jolting of the patient is avoided, while the noise and confusion that too often attends the transfer of a sick person to a hospital ward, is rendered unnecessary.

Adjoining every ward is a small but well furnished room for the ward-master. One window in the side of the room allows the ward-master to observe the patients. In this room is kept the medicine prescribed during the morning visit of the medical officer. The nurses employed, in both the female and male wards, are nearly all female nurses, middle-aged. The female nurses appear to perform their, at times necessarily unpleasant duties, with great efficiency.

Approaching the culinary department in an adjoining building to the north wing, I noticed a three-wheeled vehicle being loaded with dinner for the patients. This drosketax, as it is called, is a hand-wagon, five feet long, two and a half feet wide, and four feet high, fitted with four shelves and three wheels, all made of iron. Upon the shelves were eight three-quart bowls of beef-soup, twelve earthen plates of roast beef, potatoes, and onions, twelve plates of fresh fish, and twelve cups of custard. As soon as each wagon was loaded, it was wheeled along the hall of the lower floor and into the wards, or hoisted by the dumb-waiter into the second and third floors.

The kitchen is large and airy; a flood of light is thrown into it by numerous windows in the roof and the sides of the building; it is an easy matter to keep it scrupulously clean, not a dark corner exists, for the convenience of an indolent cook. Two copper kettles, capacity forty gallons each, are for coffee and tea; four copper kettles, of same capacity, are for soups; four tanks, of iron, are for cooking the meats and vegetables. All the cooking is done by steam. The diet for every patient for the day is written down on printed forms in a journal three feet square and eight inches thick, and is always referred to in the kitchen at the time of serving out the meals. The pantry and preparatory room for dressing the food adjoins the kitchen. An abundant supply of hot and cold water is here observable, as indeed it is in all parts of Kommune Hospital. The general bath-rooms

are in a separate building, all are fitted with the douche of hot and cold water, the hip-bath, and foot-bath. The basement of the north wing contains the alkaline bath, mercurial bath, electric bath, vapor bath, warm-air bath, medicated bath, and sulphur bath.

I regret to notice that the old style of washing by hand-labor is still carried out in this Hospital. Large zinc vats cemented in bricks are used by the washerwomen. The wringing is performed by placing the clothes in an iron tub perforated like a sieve, and placed on a pivot; a belt connected with the steam-engine causes the sieve to whirl rapidly, the moisture exudes by centrifugal force. The ironing is accomplished by a mangle moved by machinery, it is similar to the mangles used in hotels. The drying-room is heated by steam to 98° centigrade. An ample supply of attendants was observable in all parts of the building. No expense has been spared to fit up this Hospital with all the appurtenances for the treatment of disease. It certainly is a great credit to the liberality and humanity of the Danes. It was built in 1859-61, and is well worth a visit by every medical man.

J. B. SCHOFIELD.

DOMESTIC.

Belladonna an Antidote for Opium.

EDITOR MEDICAL AND SURGICAL REPORTER:

Wishing to add my testimony of the aptidotal properties of belladonna in opium-poisoning, I send you the following, which occurred in my practice.

July 21st, 1866. I was hastily summoned to see E. H.; messenger said he had taken poison. I arrived at 11.30, P. M. Found patient a man of nervo-bilious habits, æt. 30 years. Had taken three ounces of tr. opium at 8 o'clock. This he stated in a letter found on his table, and further substantiated by two two-ounce vials, which were found in his boots. One was empty, the other was half full of laudanum.

The drug showed its full effect, having been taken three hours and a half previously. The friends had discovered his condition an hour after he took the poison, and had tried to produce emesis with mustard and warm water, until they had given a pint, also by tickling his fauces with an oiled feather, but to no purpose. I found the patient covered with a cold clammy sweat; extremities cold; pulse 110, and intermittent; respiration seven, and stertorous; pupils mere points; nose pinched like a cadaver, and could not inspire through it. Had had

spasms of the muscles before I arrived. All efforts to arouse by shaking and flagellation proved useless.

With great difficulty I administered twenty grains of sulphate of zinc, but with no perceptible effect. I then gave twenty drops of TILDEN'S fluid extract of belladonna (which I knew to be a reliable preparation) every ten minutes, until three doses were given, when his pupils began to dilate. In twenty minutes from the time he took the last dose, they attained their normal size.

As soon as the pupils began to dilate, consciousness began to return, and when they were fully dilated, the patient could be aroused, and would answer to his name when loudly called.

22d, 1 o'clock, A. M. Pulse 106, and regular; respiration seven; pupils twice their normal size. Could be aroused by severe flagellation and loudly calling his name.

He remained in this condition until three o'clock, when it became more difficult to arouse him. I again gave ten drops of the belladonna every ten minutes until he had taken forty drops, with but little or no change, except the further dilating of his pupils. At 4 o'clock, patient could not be aroused as before, or with a battery, which I now applied and used faithfully for an hour. At 7 o'clock, patient showed signs of improvement, and at 10 o'clock, could sit up in bed, and called for water. I ordered gruel to be given during the day, and a cathartic at night.

23d, 10 o'clock, A. M. Found patient sitting up, and perfectly rational, with slight gastric irritation and feeling of dulness, and some soreness, the effects of flagellation received from our hands in trying to keep him aroused. I am sure the belladonna saved this man's life.

H. J. HORTON, M. D.

Berlin, N. Y., Aug. 1866.

History of a Case of Cholera.

EDITOR MEDICAL AND SURGICAL REPORTER:

In looking into the Fourteenth Volume of the REPORTER, page 355, I see an account of a case of Asiatic cholera that occurred in the village of Topsham, Maine, in February, 1832. The facts are these: A sailor arrived at his home in Topsham, from Europe, having had cholera in Bremen, where, as well as on the continent, the disease was very prevalent. After coming on board ship he trailed his clothes for several days, when they were dried, and deposited in his chest among some trinkets for a little sister. She unpacked them the evening of his arrival. About two o'clock the following morning the little girl was

taken violently sick, and Prof. McKEEN was called, and seeing some symptoms unusual, asked Professors MUSSEY and DE LAMATER to call in. They were unanimous in the opinion that it was a case of Asiatic cholera. There had been at that time no cases of Asiatic cholera in the country.

I. MORRELL, M. D.

Fulton, N. Y., August 21, 1866.

On the Use of Chloroform in Delirium Tremens. EDITOR OF MEDICAL AND SURGICAL REPORTER:

Was called on the morning of the 14th inst., to see J. W. H., æt. 32, suffering from delirium tremens. Being in good circumstances, and a free liver, he had been drinking freely during the past week. On inquiry I found that during the past four days he had been able to procure but little sleep, and was in an extremely excitable condition. As the secretions were diminished, I hesitated giving opium, and placed him upon tincture of lupulin, giving two drachms every hour, enjoying perfect quiet in a dark room. This was given during the entire day, and with little effect. He was now extremely excitable, restless, and raving.

At this juncture I began the use, internally, of chloroform, as suggested by Dr. McCLELLAN in a late number of the REPORTER. One drachm (f.ʒj.) was given every twenty minutes for four doses. The second he vomited; the others were retained. He was now quiet, though not sleeping. At the expiration of three quarters of an hour I gave him three drachms (f.ʒiij.) in a little ice-water, which he retained, and was shortly after in a gentle slumber, lasting an hour and a half, when he awoke, turned over, and slept seven hours, awaking quiet, composed, and having no recollection of the events of the past day.

A full dose of calomel was given, followed by oil, and restricting him to gentle diet,—he was soon able to resume his daily avocation.

ALVIN SATTERTHWAITE, M. D.

*Mariner's Harbor, Staten Island,
New York, August 26th, 1866.*

— KIDNAPPING SURGEONS. The Austrians, we are told by the *British Medical Journal*, try to kidnap Prussian surgeons. Thus, Dr. FRIEDLÄNDER, of Breslau, was carried off by them from the field of Oswiecim, when actually attending a wounded Austrian. Great efforts have been made to obtain his liberation, but all in vain. The Prussian military authorities offered to give Count LIPPE, an Austrian officer, in exchange for Dr. FRIEDLÄNDER. The offer was rejected. Dr. ZUCKER has also been carried off under similar circumstances by the Austrians, with a grievous wound inflicted upon him in the neck by those who captured him.

News and Miscellany.

Alcohol.

The Paris correspondent of *The London Star*

says:

"A mighty statistician, Dr. JOLLY, has just declared war against alcohol. Last year he waged a fierce combat against tobacco, but now he attacks drinkers. He does not use measured terms in his denunciations against those who use spirituous liquors, as you will remark by the following extract from the report he has just sent up to the Academy of Medicine: 'In every country the statistics of the amount of alcohol imbibed precisely correspond with the number of judicial sentences recorded in law reports of the year, as well as with the number of poor, of beggars, of vagabonds, of divorced husbands and wives, of idiot rickety children, of suicides, murders, and of epileptics and lunatics inscribed on State registers.' Whether this be correct or not, I am not prepared to say; but it is a positive fact that the consumption of spirituous liquors in France is making rapid progress. In 1788 the amount of alcohol sold did not exceed 200,000 hectolitres during the course of the year. In 1840, 1,000,000, and in 1863, 3,000,000 hectolitres were consumed. (An hectolitre is 22 gallons.) In 1840, eight litres of brandy was drank per inhabitant within the barriers of this city; 30 litres is now the average consumption per head. According to Dr. JOLLY, 300,000 Parisians daily indulge in their *petit verre*. (A litre is equivalent to an English pint and three-quarters.)"

Pension Examining Surgeons.

New York—Dr. JEREMIAH DUNN, Lodi.

Kentucky—Dr. CHARLES DUERSON, Mt. Sterling.

Iowa—Drs. WM. R. SMITH, Sioux City; WM. E. GIBBON, Mariton.

— Long before the temperance reform, a missionary from the West Indies sought medical advice from Dr. RUSH, and when a very unpalatable medicine was prescribed, the patient asked if he could not take a little "good old Jamaica" with it? "No, sir," the Doctor decidedly replied. "Why, sir, what harm will it do?" demanded the West Indian. "What harm will it do?" continued Dr. RUSH. "I am determined no man shall rise on the day of judgment and say Dr. RUSH made me a drunkard." Wise and noble reply!

— DR. NATHAN HAYWARD, of Boston, died in St. Louis on the 24th ult., of cholera. He was Surgeon of the 20th Massachusetts Regiment. After one terrible battle he operated for thirty-six hours. The strain on his energies turned his hair suddenly white.

— ARTIFICIAL LIMBS. The medical department of the army, up to May 11th, 1866, had furnished to disabled soldiers the following artificial limbs: arms, 2134; legs, 3784; hands 144; feet, 9; other apparatus, 104; at a total cost of \$357,728.

— Cholera having appeared at Aurora, Indiana, an investigation showed that the three cases that had occurred up to the 18th of August, all originated from contact with patients from other localities, and all had premonitory diarrhoea.

— The regular course of instruction in the Medical Department of the University of Nashville will begin on the first Monday of November next. The preliminary course begins on the 1st of October. This College has recently obtained the services of Prof. JOSEPH JONES, M. D., of Augusta, Ga., as Professor of Pathology. This is as great an acquisition to the Nashville school, as it is a loss to the one at Augusta.

— We have received the Annual Circular of the National Medical College at Washington, D. C., which begins its 45th annual session on the 15th of October next. It has a very full and able corps of Professors.

Army and Navy News.

ARMY.

PROMOTIONS.—The *Army and Navy Journal* contains a long list—too long for us to copy—of confirmations by the U. S. Senate, of brevet promotions of Surgeons and Assistant Surgeons of the Army, to be Captains, and Majors. All the promotions are "for faithful and meritorious services during the war," and all date from March 13th, 1865.

ASSIGNED.—Brevet Brigadier-General John M. Cuyler, U. S. Army, to duty as Medical Director, Department of the East.

Brevet Colonel William J. Sloan, Surgeon U. S. Army, to duty as Chief Medical Officer at New York City.

Brevet Colonel Thomas A. McParlin, Surgeon U. S. Army, to duty as Medical Director, Department of the Gulf.

Brevet Lieutenant-Colonel B. J. D. Irwin, Surgeon U. S. Army, relieved from duty at Fort Riley, Kansas, and assigned to duty as Post Surgeon at Fort Leavenworth, Kansas.

NAVY.

List of changes, etc., in the Medical Corps of the U. S. Navy, for the week ending September 1st, 1866.

Surgeon R. T. Maccoun, detached from the U. S. Ship Chattanooga, and placed on waiting orders.

Surgeon R. C. Dean, ordered to report on the 17th September, for duty on board the U. S. Ship Sacramento, at Boston.

Surgeon William Grier, ordered to report on the 5th September, at Hartford, Conn., for duty as member of the Board, of which Commodore S. P. Lee is President.

Surgeon George Peck reports his return to the Atlantic States, from U. S. Ship Vanderbilt, Pacific Squadron.

Passed Assistant Surgeon H. P. Babcock, ordered to report on the 17th September, for duty on board the U. S. Ship Sacramento, at Boston.

Assistant Surgeon H. N. Beaumont, detached from the U. S. Ship Chattanooga, and placed on waiting orders.

Assistant Surgeon J. Wesley Boyden died on board the U. S. Ship Muscocoa, of yellow fever, August 17th, 1866.

MARRIED.

HORN—BAKER.—In this city, August 3rd, by the Rev. Joseph T. Cooper, James H. Horn, of Springfield, Montgomery county, Pa., and Mary, only daughter of C. S. Baker, M. D., of Philadelphia.

KNIGHT—CORNELL.—August 29, in this city, by the Rev. W. M. Rice, D. D., John Knight, M. D., of Fox Chase, 23d Ward, Philadelphia, and Miss Louisa Cornell, youngest daughter of James C. Cornell, Esq., of Northampton, Bucks county, Pa.

PUTNAM—GLENN.—In Knoxville, Tenn., August 23d, Dr. A. C. Putnam and Miss Hattie, daughter of John Glenn, Esq., all of Knoxville.

DIED.

ALMY.—In St. Paul, Minnesota, August 22, of chronic inflammation of the stomach, Miss Maria Almy, daughter of Dr. S. O. Almy, of Cincinnati.

LEON.—On Sunday, September 2d, at Long Branch, N. J., Alexia Leon, M. D., of New York City.

McKNIGHT.—August 22d, in Chester county, Pennsylvania, Dr. Joseph G. McKnight, at the residence of his father, James McKnight, aged 35 years.

REID.—In Conshohocken, Pa., August 30, David J. Reid, infant son of Dr. J. K. and Nerina M. Reid.

ANSWERS TO CORRESPONDENTS.

Dr. S. A. B., Lucas, Ohio.—Surgeons of New York, sent by mail, August 23d.

Dr. O. P. S., Frostburg, Md.—Forceps sent by express, August 30.

Dr. J. L. P., Philadelphia.—Jones and Sieveking's Pathology, and Bennett's Practice of Medicine, sent August 27th.

Dr. G. G. L., Jerseyville, Ill.—A Microscope, Beale on the Microscope, Barker's Nitrous Oxyd, sent by express, 1st inst. A wired skeleton will cost \$45.

METEOROLOGY.

August,	20,	21,	22,	23,	24,	25,	26.
Wind.....	W.	S. W.	W.	N. E.	N. W.	N. W.	N. W.
Weather.....	Clear.	Clear.	Clear.	Clear.	Clear.	Clear.	Clear.
Depth Rain.....		2-10		6-10			
Thermometer.							
Minimum.....	60°	54°	58°	60°	49°	48°	51°
At 8 A. M.....	68	64	67	64	59	60	60
At 12 M.....	71	77	77	58	68	71	70
At 3 P. M.....	71	79	79	58	65	70	70
Mean.....	67.50	66.	70.25	60.	60.25	62.25	62.75
Barometer.							
At 12 M.....	29.9	30.	29.9	29.9	30.	30.1	30.1
Germantown, Pa.				B. J. LEEDOM.			

PHILADELPHIA SCHOOL OF ANATOMY.

College Avenue, East from Tenth St.

The Dissecting Room in this Institution, will open on September 1st, 1866. Lectures will be given during September.

The Regular Winter Course of Lectures on Special, Practical and Surgical Anatomy will begin on the 10th of October, 1866, and continue until March 1st, 1867.

Three Lectures and two examinations will be given each week, at 7 o'clock, P. M.

Fee for the Course, the same as that for Dissections and Lectures thereon in the Colleges.

R. STANSBURY SUTTON, M. D., Lecturer.
Office, 314 South 10th Street.

Janitor, JOHN CAMPBELL.

492—3m.

SUMMER SCHOOL OF MEDICINE.

No. 920 Chestnut Street, Philadelphia.

ROBERT BOLLING, M. D., JAS. H. HUTCHIN-

SON, M. D., H. LENOX HODGE, M. D.

EDWARD A. SMITH, M. D., D. MURRAY CHESTON, M. D.,

HORACE WILLIAMS, M. D.

The Summer School of Medicine will begin its second term on March 1st, 1866, and students may enjoy its privileges without cessation until October.

The regular Course of *Examinations and Lectures* will be given during April, May, June, and September, upon

ANATOMY,

SURGERY,

CHEMISTRY,

PHYSIOLOGY,

OBSTETRICS,

MATERIA MEDICA,

PRACTICE OF MEDICINE.

The subjects will be studied by the aid of Specimens, Manikins, Demonstrations, and Clinical Examinations of Patients.

Students will be given access to the Pennsylvania, Episcopal and Children's Hospitals. The employment of the Microscope, and the microscopic appearance of the tissues and fluids in health and disease, with the chemical tests and reactions, will also be taught.

FEE, \$50.

SURGERY.

A Course of Lectures on SURGICAL DIAGNOSIS will be delivered by Dr. H. LENOX HODGE, during April, May, June, and September, at the Summer School of Medicine, No. 920 Chestnut Street, Philadelphia.

The history, causes, symptoms, and pathology of Surgical Diseases and Injuries will be carefully studied, and the means of recognizing and treating such disorders distinctly taught.

Instruction will be given in the use of the Microscope, Ophthalmoscope, Otoscope, Laryngoscope, Endoscope, and other specula; in Percussion and Auscultation, and other means now employed for physical examination.

FEE, \$10.

OFFICE STUDENTS will be received at any period of the year; they will be admitted to the Summer School and to the Winter Examinations, and Clinical Instruction will be provided for them at the Pennsylvania, Philadelphia, Episcopal, and Children's Hospitals. They will be given special instruction in the Microscope, in Practical Anatomy, in Percussion and Auscultation, and in Practical Obstetrics. They will be enabled to examine persons with diseases of the Heart and Lungs, and to attend women in confinement. The class rooms, with the cabinet of Materia Medica, Bones, Bandages, Manikins, Illustrations, Text books, etc., will be constantly open for study.

The Winter Course of Examinations will begin with the Lectures at the University of Pennsylvania in October, and will continue till the close of the session.

Fee for Office Students (one year), \$100.

Fee for one Course of Examinations, \$30.

Class Rooms, No. 920 Chestnut St., Philadelphia.

Apply to

H. LENOX HODGE, M. D.,

479—530

N. W. corner Ninth and Walnut Streets.